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Exploring Value-Based Payment for Substance Use Disorder Services in the United States

SAMHSA
Substance Abuse and Mental Health Services Administration

Acknowledgments

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Executive Summary

Value-based payment (VBP) models pay health care providers based on the value rather than the volume of services. Use of these models has been concentrated in physical health services. However, due to the magnitude of substance use disorders (SUDs) in the United States, there has been a growing movement toward using VBP for SUD treatment and recovery services. VBP models have the potential to improve delivery of the integrated and coordinated care necessary for the complex and continuing needs of individuals with SUDs.

This report explores the use of VBP for SUD services in the United States. Chapter 1 provides background about VBP and alternative payment models (APMs) and SUD treatment needs. Chapter 2 summarizes evidence for each state's current progress toward implementing VBP for SUD services through a review of publicly available resources and documentation. Chapter 3 discusses the major challenges to adopting VBP for SUD services and offers potential solutions to help overcome them.

States are taking various approaches to implementing VBP for SUD treatment and recovery services. Some states are proposing and passing laws to require a portion of payments for SUD services to be tied to value. Other states are using Section 1115 Demonstration Waivers or other Medicaid waiver authority to set target VBP goals across their Medicaid managed care contracts. There are other funding streams furnished through state and federal grants and programs, such as the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act Section 1003 demonstration that enable states to use VBPs to expand capacity and increase the quality of SUD care. In addition, private providers, such as Wayspring and Eleanor Health, are partnering with managed care organizations to deliver value-based SUD care regionally. Findings suggest that as of March 2023, eight states have well developed and ongoing VBP initiatives for SUD services, while 20 states have low or no evidence of VBP for SUD treatment and recovery services and 22 states have medium evidence.

The challenges to further develop and implement VBP for SUD treatment and recovery services are highlighted in this report, and include the fragmentation between physical and behavioral health care; workforce and training issues; difficulties with measuring the quality of SUD treatment; limitations in data infrastructure and sharing capacity; and underinvestment in SUD treatment and recovery services. Potential solutions to these challenges include supporting care coordination, incentivizing provider training in SUD treatment, developing consensus on meaningful patient-centered outcome measures, and improving data and record-keeping infrastructures.

Sustainable, long-term financial and stakeholder investment is needed to support these solutions. With such support, VBP models have promising potential to improve the quality and cost-effectiveness of SUD treatment and recovery services nationwide.

CHAPTER 1

Introduction

As part of a strategy to reform health care in the United States, there has been a move to pay providers based on value of care instead of volume. The traditional method of paying for health care—known as fee-for-service—pays providers for each service provided and has been criticized for rewarding providers for the volume of services they offer rather than the value or quality of care provided. Alternative Payment Models (APMs) are an approach that considers quality and cost-efficiency of care in determining payments to clinicians.[1] APMs can be developed for specific clinical conditions, care episodes, or populations. VBP is a type of APM that rewards health care providers with incentive payments for the quality of care they give to patients.[1] These new payment approaches have become an increasingly popular means to provide high quality and cost-efficient health care.[2,3]

Fee-For-Service is a method in which doctors and other health care providers are paid for each service performed.[1]

Alternative Payment Model (APM) is a payment approach that considers quality and cost-efficiency of care in determining payments to clinicians.[1]

Value-Based Payment (VBP) is a type of APM that rewards healthcare providers with incentive payments for the quality of care they give to patients.[1]

Early VBP initiatives focused primarily on physical health services and did not include SUD and other behavioral health services. But there is growing movement toward using VBP for SUD treatment and recovery services as the burden of SUDs in the United States is immense, with unprecedented loss of life and skyrocketing associated economic costs.[3] VBP models have the potential to support the integrated and coordinated care that is necessary for the complex and continuing medical and recovery support needs of individuals with SUDs.

This report summarizes the evolving landscape of VBP for SUD treatment and recovery services. It draws from primary and secondary sources to provide a state-by-state review of the current use of VBP for SUD. The report highlights innovations, challenges, and strategies for implementing and sustaining VBP for SUD recovery services.

However, implementation of VBP is challenging given the existing gaps and fragmentation of SUD care. In addition, linking payment to outcomes is a challenge for SUDs, just as it is for other chronic diseases that require long-term care.[3] As more states begin to implement VBPs for SUD treatment and recovery services, it is important to capture early implementation practices and experiences in order to highlight opportunities for improvement and broader adoption.

Policy Support for Value-Based Payment

While not entirely novel, only since 2010 have there been policy pushes to implement VBP for health care. The Patient Protection and Affordable Care Act (ACA) laid the groundwork, and the Centers for Medicare & Medicaid Services (CMS) has led the way.[4] CMS, the largest payer of health care in the United States, has launched VBP programs such as Accountable Care Organizations, Patient-Centered Medical Homes, and Bundled Payments for Care Improvement, among many others.[4] While the details of the models vary, the overall goal of providing high quality coordinated care that reduces costs is the same for all of them.

Timeline of Relevant Events

2010

Patient Protection and Affordable Care Act (ACA) passes and includes provisions for APMs and establishes a new Center for Medicare & Medicaid Innovation (CMS Innovation Center) with the goal of transitioning the health system to value-based care by developing, testing, and evaluating new payment and service delivery models in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).[1]

2015

Passage of Medicare Access & CHIP Reauthorization Act, which ended the sustainable growth rate formula method of controlling Medicaid spending, changed the way that Medicare rewards clinicians for value over volume, streamlined multiple quality programs, and gives bonus payments for participation in eligible APMs.[4]

2017

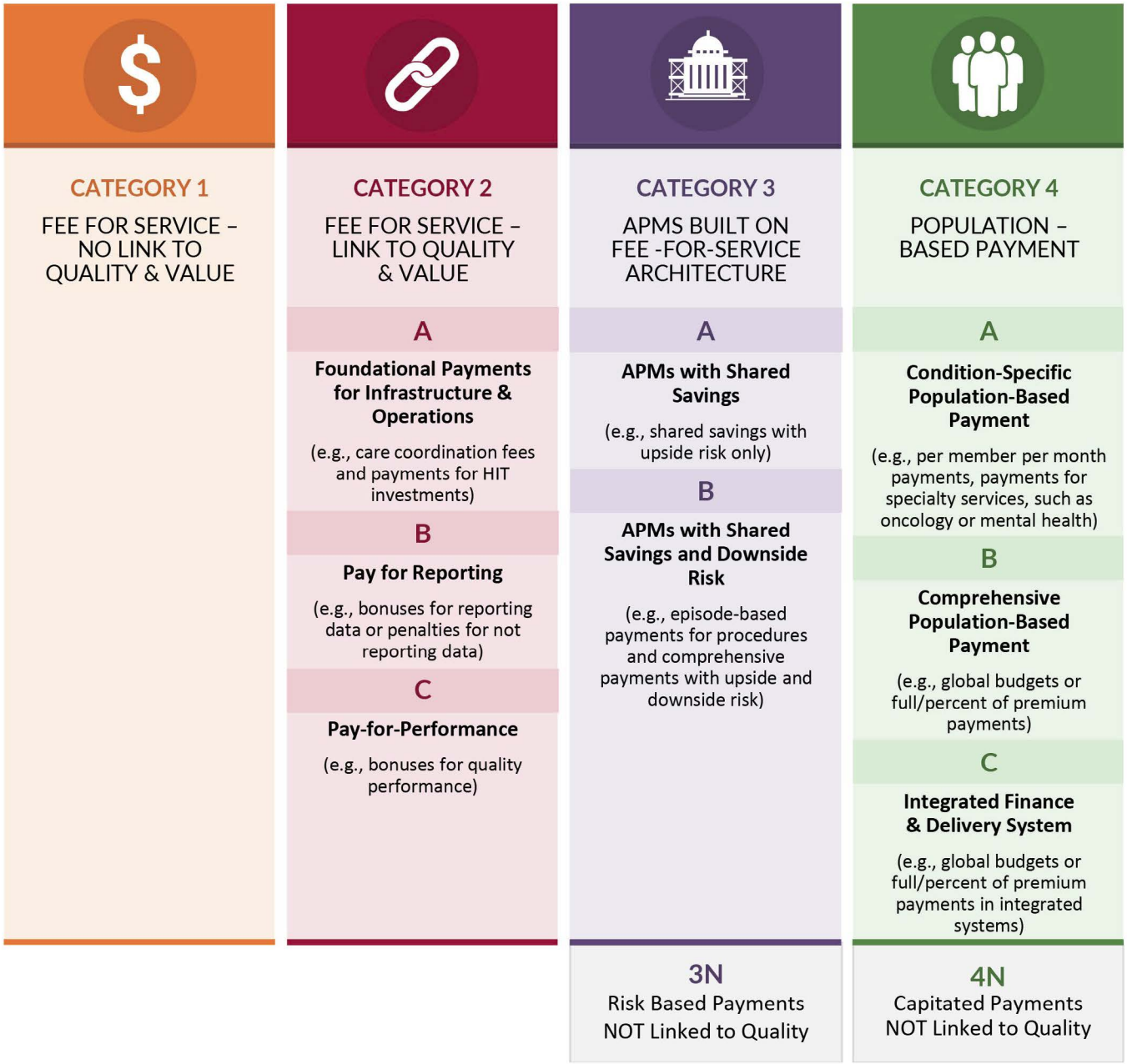
CMS announces its goal to work with states through demonstrations authorized under the section 1115 authority to improve Medicaid beneficiaries' access to high quality, evidence-based treatment services for dependence on opioids or other substances in cost-effective treatment settings while also improving care coordination and care for comorbid physical and mental health conditions.[5]

2021

CMS announces a goal of having every Medicare beneficiary and most Medicaid beneficiaries in a care relationship with accountability for quality and total cost of care by 2030.[6]

Health Care Payment Learning & Action Network APM Framework

In order to drive alignment in payment approaches across health care in the United States, the CMS Innovation Center created the Health Care Payment Learning & Action Network (HCP-LAN).[7] The HCP-LAN developed a multi-dimensional framework (as shown below) to categorize the continuum of APM models.[7] This framework is becoming widely used and simplifies the process of making comparisons and measuring progress.[8,9] The state-by-state review of the current use of VBP for SUD in Chapter 2 of this report classifies state's VBP activity using this framework.



Source: https://hcp-lan.org/apm-framework/

Substance Use Disorder Continuum of Care

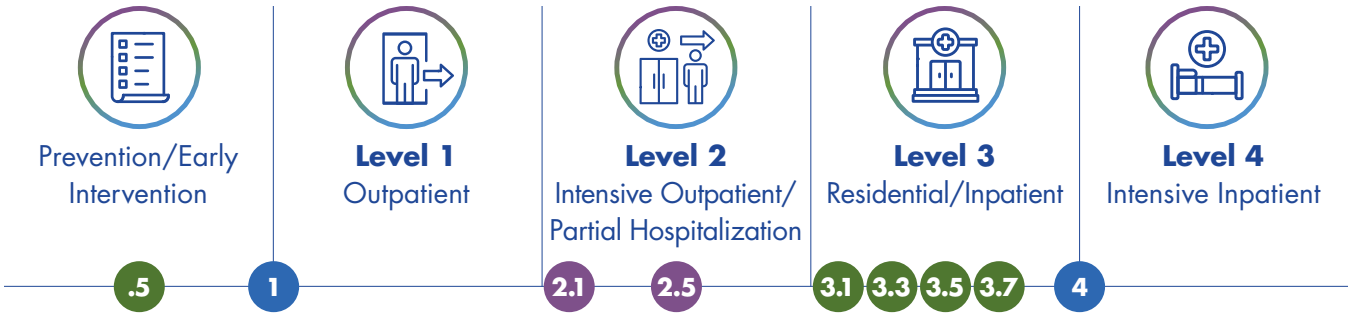
SUD has a wide range of health impacts, and the need to provide SUD treatment and recovery services that account for its continued complexities is stated in the 2016 Surgeon General's Report Facing Addiction in America.

The Surgeon General's Report also notes the importance of Recovery-Oriented Systems of Care, which emphasizes that SUDs are most effectively addressed through a chronic care management model that includes longer term, outpatient care; recovery housing; and recovery coaching and management checkups.[10]

The emergence of VBP for SUD services affords an opportunity for integrating the different levels of care to address each individual's needs and provide the best care possible. The American Society of Addiction Medicine (ASAM) developed a continuum of care identifying the different service levels that each person with a SUD may need.[11] CMS and SAMHSA have identified the ASAM criteria as an evidence-based diagnostic and treatment guidelines and a standard of care for SUD treatment.[5,12] The different levels of care on the ASAM continuum have usually been covered in isolation from each other in fee-for-service structures, either through encounters, procedures, or per diem day rates.

> "Addiction is a chronic neurological disorder and needs to be treated as other chronic conditions are."[10]

ASAM Continuum of Care | Adult[11]



- **.5** | Early Intervention
- **1** | Outpatient Services
- **2.1** | Intensive Outpatient Services
- **2.5** | Partial Hospitalization Services
- **3.1** | Clinically Managed Low-Intensity Residential Services
- **3.3** | Clinically Managed Population-Specific High-Intensity Residential Services
- **3.5** | Clinically Managed High-Intensity Residential Services
- **3.7** | Medically Monitored Intensive Inpatient Services
- **4** | Medically Managed Intensive Inpatient Service

The Magnitude of Substance Use Disorders

The need for access to high quality and cost-effective SUD services has become even more critical as SUDs and fatal overdose has reached new heights since the COVID-19 pandemic began.[13]

Evidence around the impact of VBP on SUD services is preliminary but has shown some reduction in health care costs and improved provider performance.[8,9] In addition, qualitative research with behavioral health care providers found that VBP models allowed providers to give more person-centered and flexible care.[9] However, there is a lack of data on the impact of VBPs on clinical outcomes.[3,9] Like other chronic illnesses, long-term SUD outcomes are difficult to measure, which can make it challenging to assess value of care.[8,9,16]

Substance Use Disorders in the United States

In the past **20 years,** deaths from drug overdose have **increased fivefold**[13]

Overdose deaths rose by over

30%

between 2019 and 2020

15%

between 2020 and 2021[13]

In 2020, the economic costs associated with opioid use and overdose deaths was

$1.5 Trillion[15]

106,699

drug overdose deaths occurred in 2021[13]

94%

of people aged 12 or older with illicit drug or alcohol disorder did not receive any treatment in 2021[14]

Use of Value-Based Payment for Substance Use Disorders

The increasing toll of SUDs since the COVID-19 pandemic highlights the need to provide more effective strategies to deliver and reimburse SUD treatment and recovery services. VBP use for SUD services offers a means to improve the cost-efficiency and quality of care necessary to improve SUD patient outcomes. This report describes the way APMs and VBP models are categorized, provides a summary of states' use of VBP for SUD services, describes sources of funding for these services, and includes examples of innovative programs. In addition, the report presents challenges to implementing VBP for SUD treatment and recovery services and provides strategies to overcome them.

Research Questions

What progress have U.S. states and the District of Columbia made toward implementing VBP for SUD?

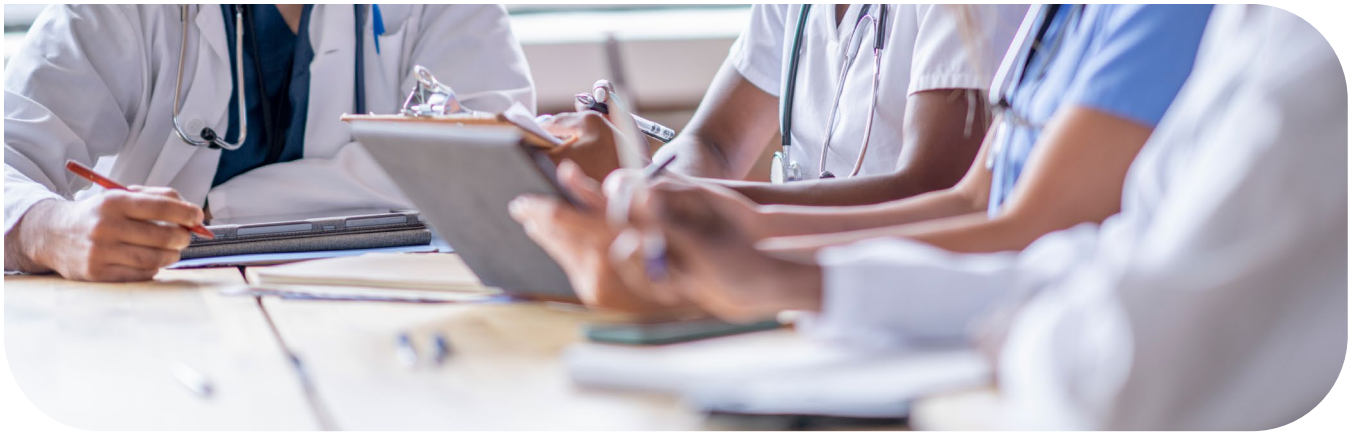
What are some innovative approaches currently being taken toward using VBP for SUD?

What are key challenges and possible solutions to broader use of VBP for SUD services to support treatment and recovery?

CHAPTER 2

State-by-State Review

This chapter reviews the use of VBP for SUD treatment and recovery services in all 50 U.S. states and the District of Columbia, including steps being taken by Medicaid, Medicare, private stakeholders, and within state legislation to adopt VBP for SUD services as of March 2023. It provides an overview of where states fall along the HCP-LAN APM Framework in their current treatment and recovery implementation of VBP for SUD. Each state's use of VBP for SUD is summarized in table format. In addition, the chapter highlights several specific innovations revealed by the state-by-state review.



Methodology

We conducted a state-by-state review of data from various public sources to gather information on VBP arrangements specific to SUD from January to March of 2023. Our research began by reviewing publicly accessible announcements or press releases from each state that discussed the formation or performance of VBP arrangements. This allowed us to gather information about private and public partnerships with organizations facilitating VBP. Next, we examined the state's current or pending 1115 Medicaid waiver or state Medicaid websites to identify any language or goals related to using VBP or transitioning to value-based models for SUD treatment and recovery.

Finally, we reviewed standard Medicaid Managed Care contracts between the state and payers to identify any language requiring VBP for SUD services. We also reviewed comprehensive publications that aggregated VBP activities.

There are limitations to this review. It is based on publicly available information and our interpretation of this material. It is likely that there are ongoing or pending VBP SUD programs that our research did not find. The findings should be interpreted with an awareness of these limitations, and the understanding that they may not fully represent current or planned activities within each state, and that programs may also change over time.

Overview of Findings

States are taking various approaches to implementing VBP into SUD treatment and recovery care delivery. Some states are proposing and passing laws through the legislature to require a portion of payments to be tied to value. Many other states are using 1115 demonstrations or other waiver authority to set target VBP goals across their Medicaid program. There are other funding streams furnished through state and federal grants and programs, such as the SUPPORT Act Section 1003 demonstration, that enable states to use VBPs to expand capacity and increase quality of SUD care. In addition, private providers, such as Wayspring and Eleanor Health, are partnering with managed care organizations to deliver value-based SUD care regionally.

8 states have well developed and ongoing VBP initiatives for SUD treatment and recovery services

20 states have low or no evidence of VBP programs for SUD treatment and recovery services

24 states have SUD performance measures for quality payment incentives in their Medicaid program

Policy Levers Used for VBP

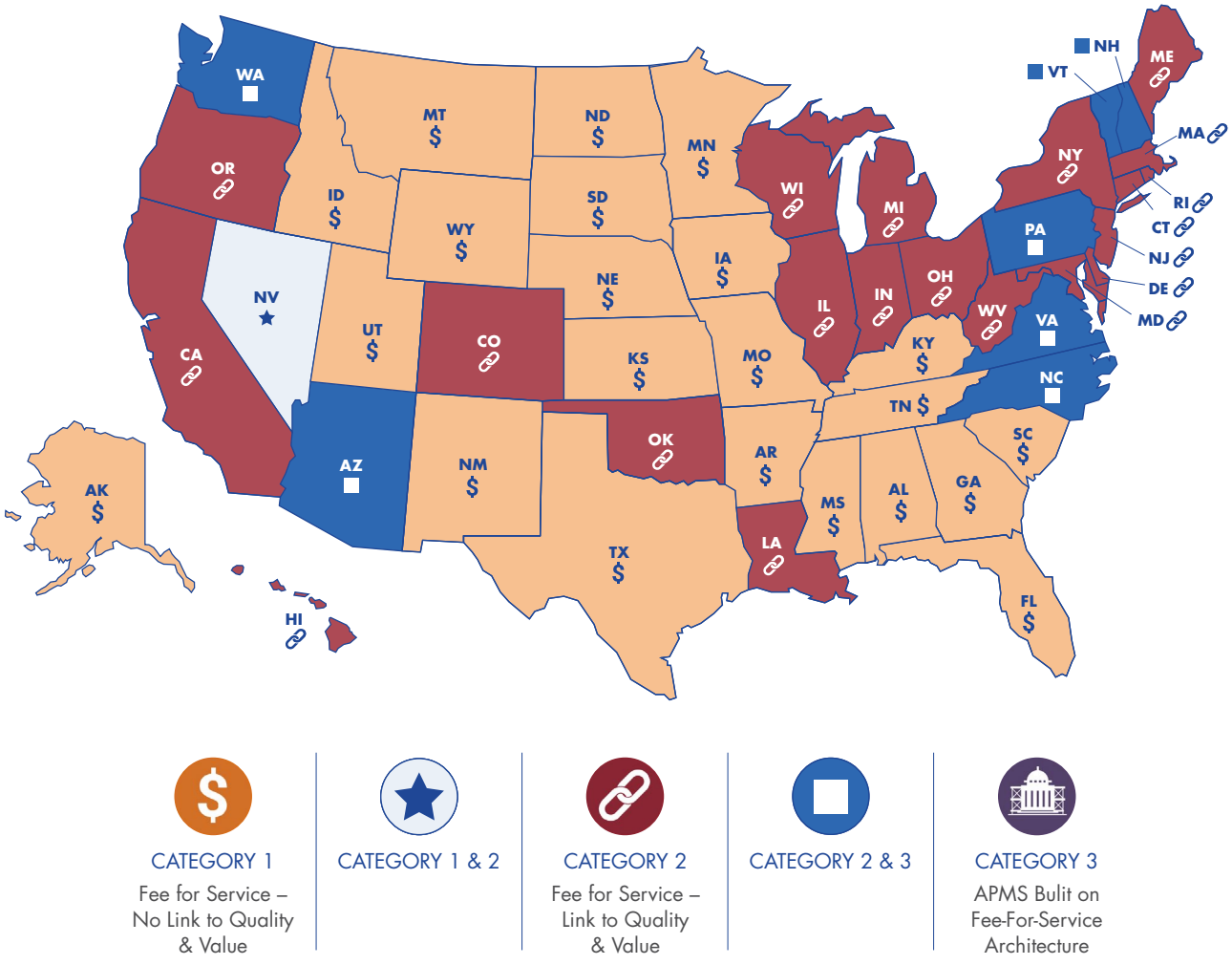
Medicaid 1115 Demonstration waivers. CMS created an opportunity under the authority of section 1115(a) of the Social Security Act for states to demonstrate and test flexibilities to improve the continuum of care for beneficiaries with SUDs.[17] These waivers usually reflect the goals of CMS and presidential administrations.[17]

In 2018, the **Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act** became law. Under section 1003 of the SUPPORT Act, CMS in consultation with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Agency for Healthcare Research and Quality (AHRQ), is conducting a demonstration project to increase the treatment capacity of Medicaid providers to deliver SUD treatment and recovery services.[18] Fifteen states were awarded planning grants for 18 months and five of these states were awarded funds for a 36-month post-planning period of the demonstration project.[18]

When a state is planning to make a change to its program policies or operational approach, states send **state plan amendments (SPAs)** to CMS for review and approval. States also submit SPAs to request permissible program changes, make corrections, or update their Medicaid state plan with new information.[19] SPAs can include changes to implement VBPs.

State Classification of VBP for SUDs Using the Health Care Payment Learning & Action Network APM Framework

The map below depicts the classification of states based on their use of VBP for SUD treatment and recovery services, using the HCP-LAN APM Framework. Our review did not uncover evidence of VBP approaches to SUD services in specific U.S. territories or the Indian Health Service, and they are not included in the map. Our categorization process was based on information gathered from each state's current or pending SUD policies. Out of all the states reviewed, 20 were classified in Category 1, which indicates the use of traditional fee-for-service methods to pay for SUD treatment and recovery services. Twenty-one states were placed in Category 2, as they use a VBP strategy for SUD that links value or quality to fee-for-service payments. Examples of these VBP strategies include payments for infrastructure or operations to enhance the availability of medication treatment for opioid use disorder (MOUD) and bonus payments to providers reporting treatment quality outcomes. It is important to note that our review did not find evidence of any states currently using VBP strategies for SUD treatment and recovery services that fully align with either Category 3 or Category 4 of the HCP-LAN APM Framework. In addition, nine states and the District of Columbia were classified between categories or using multiple approaches, as illustrated on the map.



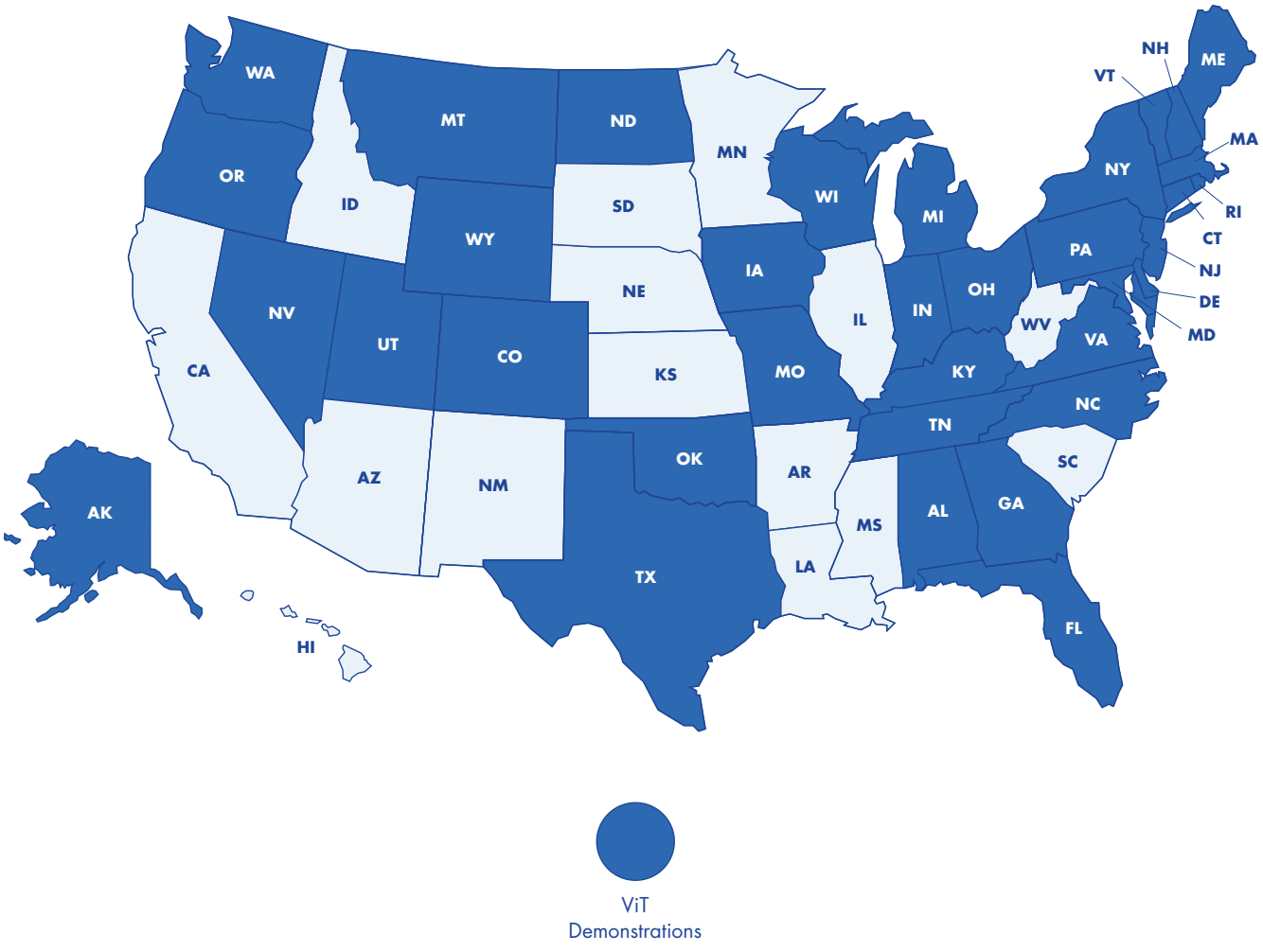
Policy and Funding Approaches to VBP for SUDs

Medicaid 1115 waivers are a widely used approach to increase coverage for SUD services. In 2017 CMS issued the following guidance: *"CMS seeks to work with states through demonstrations authorized under the section 1115 authority…to improve Medicaid beneficiaries' access to high quality, evidence-based treatment services for addiction to opioids or other substances, ranging from acute withdrawal management to ongoing chronic care for these conditions in cost-effective treatment settings while also improving care coordination and care for comorbid physical and mental health conditions."*[17] CMS requires 1115 SUD Demonstrations to meet ASAM criteria or other nationally recognized, evidence-based SUD program standards. Currently, 37 states have approved SUD 1115 Demonstration waivers and three states have waivers pending with CMS for review.[17] While 1115 waivers do not require value-based approaches to care, some state waivers do include them.

The details of the demonstration projects vary across states, but all 40 states' 1115 demonstration proposals included a request to waive the Institutions for Mental Diseases (IMD) exclusion. The IMD exclusion prohibits use of federal Medicaid funds to treat enrollees ages 21–64 in facilities that have more than 16 beds that are primarily engaged in providing psychiatric or SUD treatment including inpatient psychiatric hospitals and residential treatment settings.[17] Waiving this exclusion allows Medicaid to cover the cost of treatment for SUD services in an IMD, thus improving access to vital treatment service.[20] Twenty-six waivers also include language or policies for coverage for community-based services (e.g., supportive housing, supported employment, and recovery support services). All states participating in this demonstration opportunity are expected to be working to improve community-based care as well as providing access to more acute care settings. These waivers have helped lay a foundation for improved coverage of SUD treatment and recovery services.

In 2021, the CMS Innovation Center implemented the Value in Opioid Use Disorder Treatment (ViT) initiative. ViT is a demonstration program authorized under the SUPPORT Act Section 6042.[21] This four-year demonstration will test whether two VBP models (a per beneficiary per month care management fee and a performance-based incentive) for opioid use disorder (OUD) treatment services can reduce hospitalizations and improve health outcomes for individuals with OUD. There are 54 participating sites in 36 states and the District of Columbia.[21] Individuals eligible to participate in the program include Medicare Fee-For-Service beneficiaries and those dually eligible for Medicare and Medicaid.

States with ViT Demonstrations[22]



Overview of State Approaches to VBP for SUD

The tables below provide information on VBP activities for SUD services in each state and the District of Columbia as of March 2023. Our review did not uncover evidence of current or prospective VBP approaches to SUD services in specific U.S. territories or the Indian Health Service, and therefore they are not included in the tables. It is important to note that our review only covers publicly available information.

Our categorization process grouped states as having low, medium, or high evidence of VBPs for SUD services at the state level. States categorized as low evidence have limited or no publicly available information on current or prospective VBP SUD efforts at the state level. States with medium evidence have a SUD Performance Incentive attached to quality performance in their Medicaid program, have other pay-for-performance programs, or are working with a private entity to support VBPs for SUD. In contrast, states with high evidence have publicly available information indicating active and ongoing VBP arrangements and strategies for SUDs. In the policy/funding approach column, you can find information on the variety of funding streams or policy levers each state is utilizing to support their VBP arrangements. The final column includes links to policies, contracts, or press releases about these approaches, providing additional resources for those seeking more information.

State	Evidence of VBP for SUD	Policy/Funding Approach	SUD Performance Incentive*	Other Comments
Alabama	Medium	1115 Waiver	Yes	Statewide CCBHC Implementation in 1115 Waiver
Alaska	Low		No	No programs found
Arizona	High	1115 Waiver Medicaid State Plan	Yes	SUD/Opioid Use Disorder (OUD) COE with requirements in MCO Contracts
Arkansas	Low		No	No programs found
California	Medium	Medicaid State Plan	Yes	Enhanced Payment for beneficiaries with SUD
Colorado	Medium	1115 Waiver	Yes	Task force recommends VBP SUD Arrangements
Connecticut	Medium	1115 Waiver 1003 SUPPORT Act	Yes	SUD VBP considerations in 1115 Waiver and in 1003 SUPPORT Act

*As of July 2021

State	Evidence of VBP for SUD	Policy/Funding Approach	SUD Performance Incentive*	Other Comments
Delaware	Medium	Private Partnership	No	Private Partnership Press Release
D.C.	Medium	Private Partnership	No	Private Partnership Press Release
Florida	Low		No	No programs found
Georgia	Low		No	No programs found
Hawaii	Medium	Medicaid State Plan	Yes	Pay for Performance Quality Measures
Idaho	Low		No	No programs found
Illinois	Medium		Yes	Pay for Performance for Quality Measures in MCO Contract
Indiana	Medium	State Plan Private Partnership	Yes	Pay for Performance on Measures in MCO Contract Private Partnership Press Release
Iowa	Low		No	No programs found
Kansas	Low		No	No programs found
Kentucky	Low		No	No programs found
Louisiana	Medium	Medicaid State Plan	Yes	Pay for Performance for Quality Measurers
Maine	High	Medicaid Health Home State Plan Amendment	No	OUD Health Home Model with Pay for Performance
Maryland	Medium	Medicaid Health Home State Plan Amendment	No	OUD Health Home

*As of July 2021

State	Evidence of VBP for SUD	Policy/Funding Approach	SUD Performance Incentive*	Other Comments
Massachusetts	Medium	1115 Waiver	Yes	Pay for Performance for Quality Measures
Michigan	High	Medicaid Health Home State Plan Amendment	Yes	OUD Health Home Model with Pay for Performance
Minnesota	Low		No	No programs found
Mississippi	Low		No	No programs found
Missouri	Low		No	No programs found
Montana	Low		No	No programs found
Nebraska	Low		No	No programs found
Nevada	Medium	1003 SUPPORT Act	No	SUD Sustainability Plan recommends APM development
New Hampshire	High	Medicaid State Plan	Yes	MCO Contract requires MOUD APM and Pay for Performance for Quality Measures
New Jersey	Medium	Medicaid State Plan	Yes	Pay for Performance for Quality Measures
New Mexico	Low		No	No programs found
New York	Medium	1115 Waiver Medicaid State Plan	Yes	Pay for Performance for different programs for like HARP and TCGP
North Carolina	Medium	Private Partnership	No	Private Partnership

*As of July 2021

State	Evidence of VBP for SUD	Policy/Funding Approach	SUD Performance Incentive*	Other Comments
North Dakota	Low		No	No programs found
Ohio	Medium	Medicaid State Plan	Yes	Pay for Performance for Quality Measures
Oklahoma	Medium	1115 Waiver	No	Pay for Performance for Quality Measures
Oregon	Medium	1115 Waiver	Yes	Pay for Performance for Quality Measures
Pennsylvania	High	State Plan	Yes	Hospital Incentive Pay for Performance MCO Contract with OUD COE Model
Rhode Island	Medium	Medicaid Health Home State Plan Amendment	No	OUD Health Home
South Carolina	Medium	State Plan	Yes	Pay for Performance for Quality Measures
South Dakota	Low		Yes	No programs found
Tennessee	Low		Yes	No programs found
Texas	Low		No	No programs found
Utah	Low		No	No programs found
Vermont	High	Medicaid Health Home State Plan Amendment Medicaid State Plan	Yes	OUD Health Home and Residential Episode Case Rate

*As of July 2021

State	Evidence of VBP for SUD	Policy/Funding Approach	SUD Performance Incentive*	Other Comments
Virginia	High	Medicaid State Plan 1115 Waiver	Yes	Provider incentives through Addiction and Recovery Treatment Services (ARTS) 1115 Waiver Encourages APM for MOUD
Washington	Medium	Medicaid State Plan State Legislature	Yes	Pay for Performance for Quality Measures Funding for SUD APM in proposed state budget
West Virginia	High	State Legislature	Yes	Residential pay for performance measures passed through SB 419
Wisconsin	Medium	Medicaid Health Home State Plan Amendment	Yes	OUD Health Home
Wyoming	Low		No	No programs found

*As of July 2021

Innovations in Implementing VBP for SUD Services

This section provides six different examples of innovations in implementing VBP for SUD. These innovations were carried out by three states, one local area, and two treatment providers. The following examples do not include all innovative state initiatives or all the private partnerships engaging in VBP for SUD services.

Caron Treatment Centers

CATEGORY 2
Fee for Service – Link to Quality & Value

Caron Treatment Centers (Caron) is a nonprofit SUD treatment provider offering person-centered care services across the care continuum with locations in multiple states, including Florida, Georgia, New York, Pennsylvania, and the District of Columbia. For several years, Caron has been moving away from traditional fee-for-service contracts. In 2017, Caron and the commercial insurance provider Independence Blue Cross entered into a value-based care arrangement where Independence Blue Cross reimburses Caron a flat fee for treatment, and Caron is at risk for any readmission costs within 90 days of discharge.[23] Early evidence suggests positive impacts of Caron's VBP initiative on the outcomes of individuals in recovery. In 2019, Caron reported a 5.6% readmission rate at 90 days, a stark difference from other Independence Blue Cross members' experiences of 90-day readmission rates, which range from 11.6% to 25.7 at non-Caron facilities.[23]

Authority: Private Nonprofit
Funding Source: Private Payer Partnership

Geisinger

CATEGORY 3
APMS Bulit on Fee-For-Service Architecture

Geisinger is an integrated health system and Medicaid Managed Care Organization located in Pennsylvania. Geisinger is using VBP to increase access to SUD treatment through a bundled payment for MOUD.[24] Specifically, the retrospective bundle provides a per member per month payment to primary care or substance use conditions providers administering buprenorphine or Vivitrol. Early 2018 outcomes found a 25% reduction in emergency department cost of care, a 25% reduction in inpatient cost of care, and 42% retention in MOUD.[24]

Authority: Integrated Health Plan, MCO Contract
Funding Source: Medicaid

New Hampshire

CATEGORY 2

Fee for Service – Link to Quality & Value

New Hampshire's 2019 Medicaid Managed Care Contract provided new requirements for implementing VBP for SUD. It directed that state managed care organization plans include enhanced payments to providers that become certified in and provide MOUD to up to 30 (for enhanced payment tier 1) or 100 (enhanced payment tier 2) Medicaid members per quarter.[25] It also required that managed care organizations develop at least one APM designed to improve access to MOUD, and at least one APM for treating infants born with neonatal abstinence syndrome.[25] Although contracts between managed care organizations and state Medicaid departments often list goals toward achieving VBP targets, it is rare for goals to be explicitly tied to SUD treatment or recovery.

Authority: MCO Contract
Funding Source: Medicaid State Plan

Nevada

CATEGORY 2

Fee for Service – Link to Quality & Value

In June 2021, the Department of Health Care Finance and Policy published Nevada's Sustainability Plan to Support Expansion of SUD and OUD (Opiate Use Disorder) Treatment and Recovery Provider Capacity through funding furnished by the SUPPORT Act planning grant.[26] This sustainability plan contains five sections, including a financial assessment, which identifies long-term economic sustainability efforts to finance SUD and OUD treatment and recovery. One VBP-linked goal of the plan is to obtain ongoing state funding to provide monetary incentives to providers meeting certain use thresholds for SUD recovery services.[26] The plan also establishes the goal of reimbursing providers for recovery support tools. Another goal of the plan is to implement the Patient-Centered Opioid Addiction Treatment Model, which aims to improve standards of care for OUD and align reimbursement in outpatient settings through bundled payments based on the initiation and maintenance of MOUD.[26]

Authority: State
Funding Source: 1003 SUPPORT Act Post-Planning Funding

CATEGORY 2

Fee for Service – Link to Quality & Value

New York

Staten Island in New York created their Performing Provider System (PPS) in 2014 under the New York State Department of Health Delivery System Reform Incentive Payment Program. The PPS is an alliance of clinicians and social service providers with multiple goals, including improving access and capacity to high-quality SUD care.[27] To achieve this aim, the PPS furnished enhanced payments to primary care providers that become waivered to prescribe MOUD. It also provided incentive payments to primary care physicians engaged with PPS's withdrawal management services. The PPS offers other initiatives and funding to support primary care physician offices in hiring additional staff to improve the infrastructure needed to integrate SUD care. By 2020, the Staten Island PPS saw a 400% expansion in access to MOUD through these VBP strategies.[27]

Authority: Independent Practice Alliance
Funding Source: State Funds

CATEGORY 2

Fee for Service – Link to Quality & Value

West Virginia

In 2022, the West Virginia legislature passed Senate Bill 419 requiring the Department of Health and Human Resources to establish a pilot program contracting performance-based residential SUD treatment with facilities in three counties.[28] The pilot program mandates the provision of community-based services, including peer supports, to support recovery for up to 3 years after individuals begin residential treatment for SUD. The program will include an evaluation of the effectiveness of these performance-based services on long-term outcomes for those in recovery, providing a much-needed contribution to the evidence base.

Authority: State Legislation
Funding Source: State Funds

CHAPTER 3

Challenges and Potential Solutions to Implementing Value-Based Payment for Substance Use Disorder Services

Implementing VBPs for SUD services presents numerous overlapping challenges that not only hinder the implementation of VBP approaches for SUD treatment and recovery services, but also the evaluation of care quality and value. Through an environmental scan and literature review, this chapter identifies the most significant challenges to implementing VBP for SUD and offers potential solutions to address these challenges.

Care Fragmentation

Challenge

Behavioral and physical health care providers have a long history of operating in different care silos with different administrative and regulatory structures for physical health, mental health, and SUD care. This fragmentation of care can make it difficult to provide the comprehensive continuum of treatment recommended for recovery from SUD, which is a chronic and often recurring condition.[3,8,29] Federal billing and treatment regulations may act as further barriers to treatment integration.[3,29] Care coordination is often not financially incentivized and can be difficult for health care providers to manage in addition to their standard caseload.[3] Care coordination, community wrap-around services to provide long-term support for individuals in recovery, and the integration of primary care and specialty SUD treatment are necessary to improve the ability to provide high quality SUD services. Care fragmentation makes it difficult to link care, including follow-up care, to quality measures, which is an essential component of VBP.

Potential Solutions

- Develop or enhance partnerships and coordination between state Medicaid leaders and mental health and substance use disorder agencies to promote alignment of efforts, funding, and infrastructure.
- Support the development of Independent Practice Alliances, provider networks, or other center-of-excellence-type approaches that provide payers with a single contracting point of entry for an entire continuum of care for SUD in a local community.
- Support the use of mobile technology engagement, including telehealth, that can encourage longer patient retention and augmentation of in-person treatment and recovery support services being provided.[30]
- Develop partnerships between community-based SUD providers including peer services and Emergency Departments, Primary Care, Federally Qualified Health Centers (FQHCs) Public Health Departments, and Criminal Justice Systems.
- Encourage utilization of the Behavioral Health Integration codes created by the 2023 Medicare Physician Fee Schedule final rule to pay for clinical psychologists and licensed clinical social workers to provide integrated behavioral health care as part of a primary care team. These codes will help support integration of care and could be the building blocks for VBP initiatives for SUD treatment and recovery services.[31]

Workforce and Training

Challenge

Many providers do not currently have the workforce capacity to transition to and implement VBP for SUD services and need training and support to adopt these payment approaches.[3] For example, providers may not have the workforce capacity needed to utilize VBP reimbursement and to provide care coordination or MOUD, especially in rural areas.[29] There is a shortage of addiction treatment and recovery support specialists, as well as generalists with training in SUDs to meet the need for SUD treatment and recovery services. Funding to recruit, retain, and provide professional development to the range of practitioners that make up the SUD workforce is often limited. As such, implementing VBP can cause further strain on an already burdened workforce.

Potential Solutions

- Provide care transformation funding to providers to incentivize a transition from fee-for-services to VBP.
- Support training and technical assistance for VBP budgeting and administration for providers.
- Provide targeted education to providers surrounding stigma, the chronic nature of SUD, and the need for access to multiple levels and forms of care.[16]
- Support further state government and legislative action to increase funding and opportunities to train SUD specialists, including counselors and peer support specialists.[16]
- Promote the new Medicare benefit category which was created by the Consolidated Appropriations Act, 2023 to directly reimburse licensed mental health counselors and marriage and family therapists. This will be effective as of January 1, 2024 and will expand the available workforce for Medicare beneficiaries.[31]

Quality and Outcome Measurement

Challenge

Measuring the quality of care provided is an essential component of VBP. However, quantifying SUD treatment care quality can be difficult as there are limited existing SUD treatment quality measures, and a lack of consensus on which can be tied to improved patient outcomes and savings.[8] In addition, reporting requirements for quality measurement to receive VBP can prove burdensome to providers, acting as a further barrier.[8] Subject matter experts highlight the need for quality measures that assess meaningful treatment impacts on the lives of individuals with SUD, including patient-reported outcome measures.[3,8]

Potential Solutions

- Develop consensus on measures that can be linked to improved outcomes and reduced costs.[8]
- Utilize robust process measures in addition to patient-reported outcome measures and quality of life measures.
- Employ the preliminary Universal Foundation Measures recently included by CMS leaders to align quality measurement across CMS quality programs. Ten adult measures were developed including a measure of initiation and engagement of substance use disorder treatment. The Universal Foundation is a significant step to reduce provider burden and improve care quality.[32]

IT Infrastructure and Data Sharing

Challenge

Successful implementation of VBP requires an appropriate IT infrastructure and data collection and reporting capacity. However, many providers do not have electronic health record systems in place to assist with SUD treatment management and quality reporting for payment.[29] Additionally, providers may have electronic health record systems that are not able to integrate across health networks and efficiently bill and track patient outcomes.[29] Data sharing regulations are a related major challenge to implementing VBP for SUD.[3,8] Title 42, Part 2 of the Code of Federal Regulations prohibits certain types of treatment programs from disclosing that patients have SUD without patient consent or court order. While these regulations and the Health Insurance Portability and Accountability Act (HIPAA) are designed to protect the privacy of individuals with SUD, they can also limit the ability for clinicians to share essential treatment information and act as a barrier to integrating SUD and primary health care.[33]

Potential Solutions

- The Department of Health and Human Services has proposed changes in 42 CFR 2 (Confidentiality of Substance Use Disorder Patient Records) to better align part 2 with the Health Insurance Portability and Accountability Act as required by Section 3221 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). SAMHSA also supports a Center of Excellence for Protected Health Information to help provide materials and technical assistance to health care providers and others (https://www.samhsa.gov/center-excellence-protected-health-information-coe-phi).[34]
- Provide funding for technical assistance for IT training, billing, and any other set up costs.

Underinvestment and Sustainability

Challenge

SUD services are chronically under-funded compared to physical health care services. Stakeholders note that enduring stigma surrounding SUD contributes to the lack of funding parity and continued separation between SUD and primary health care services.[3,35] This underinvestment in SUD treatment and recovery underlies all other challenges to implementing VBP for SUD services. Although many states are moving toward leveraging 1115 waiver demonstrations to support the development of VBP for SUD services, these demonstrations provide time-delimited solutions. There is critical need for improved long-term federal, state, and health care system investment in and incentivization of SUD treatment integration, training, and infrastructure. Fortunately, some important changes are happening; the 2023 Medicare Physician Fee Schedule final rule updated Medicare coverage of OUD treatment services and increased overall payments.[31]

Potential Solutions

- Encourage decision-makers that are allocating opioid settlement funds to support SUD infrastructure development and training that support the upfront and ongoing costs of VBP activities.[35]
- Consider leveraging SAMHSA funds at the state level to help develop infrastructure to support VBP for SUD services.
- Encourage local governments to earmark taxes to fund mental health and SUD treatment and recovery services.[36]

Conclusion

In the last several decades, growth in the prevalence and severity of SUDs has taken an enormous toll on public health and the health care system. SUDs are complex and require a full continuum of treatment and recovery services to support the long-term recovery of individuals with this chronic condition. Payment models that prioritize care quality and provide coordinated, multilevel treatment are a promising means to improve the outcomes of individuals with SUD and reduce the health care costs of these disorders.

The increasing public alarm about the toll of SUD since the COVID-19 pandemic began has created a more favorable environment toward implementing VBP for SUD and integrating SUD treatment into primary health care. This report found promising evidence of states' recent and ongoing efforts to transition to VBP models and improve the treatment of SUD. These efforts are supported by mechanisms including CMS's waiver program, the CMS Innovation Center's ViT demonstration, and state-level legislation and programs.

There are many opportunities to overcome the various challenges associated with transitioning to VBP for SUD services, as noted in this report. Issues with care fragmentation, workforce insufficiencies, infrastructure, outcome measurement, and underinvestment could be improved with further guidance from federal and state stakeholders. With this support, the potential for widespread future adoption of VBP for SUD is promising. Although a more developed evidence base is needed, preliminary findings suggest that VBPs will have significant positive implications for how SUD is treated in the United States, lowering health care costs and improving quality of care.

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APPENDIX

Contributors

This publication was developed through significant contributions from the following individuals:

SAMHSA Project Leads

Steven Fry
Substance Abuse and Mental Health Services Administration

Michele LaTour Monroe
Substance Abuse and Mental Health Services Administration

Other Contributors

Lynnea Brumby
Westat

Jennifer Caputo
Westat

Ashley DeGarmo
Third Horizon Strategies

Emily Diehl
The National Council for Mental Wellbeing

John Easterday

Carolyn Frommer
Westat

Douglas Fuller
National Association of State Alcohol and Drug Abuse Directors

Shoma Ghose
Westat

Howard Goldman
University of Maryland

Brenda Jackson
Brenda Jackson Consulting, LLC.

Mustafa Karakus
Westat

Joe Parks
The National Council for Mental Wellbeing

Elian Rosenfeld
Westat

KaTysha Sirleaf
Westat

Melanie Whitter
National Association of State Alcohol and Drug Abuse Directors

Aaron Williams
The National Council for Mental Wellbeing

Greg Williams
Third Horizon Strategies

Center for Financing
Reform and Innovation

SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes.

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